



## PHARMACY HUB MEMBERSHIP FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone/Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Please indicate:

University: \_\_\_\_\_

Student: 1<sup>st</sup> Yr  2<sup>nd</sup> Yr  3<sup>rd</sup> Yr  4<sup>th</sup> Yr  5<sup>th</sup> Yr  6<sup>th</sup> Yr

Pharmacy  Dentist  Allied Health

Medical  Nurse

Pharmacy Assistant:  Pharmaceutical Rep:  Lecturer/Academic:

Membership cost:

\$10.00 per year or \$50.00 for life member.

We will inform you of all events by email or sms (you can opt out at any time).  
Membership card can be collected at the *MediADVICE* Pharmacy Hub.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_